



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

UNIVERSITY MEDICAL CENTER

Respondent Name

STARR INDEMNITY & LIABILITY CO

MFDR Tracking Number

M4-17-0124-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting a Medical Dispute because insurance carrier has underpaid the DRG with implants carved out. I submitted a reconsideration with a copy of the PC pricer explaining that insurance underpaid the DRG. I am not questioning the payment of the implant invoices."

Amount in Dispute: \$264,475.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Late filing as to DOS: The provider's request was not datestamped as received by DWC MRD until 9/15/16. Consequently, it is not timely as to DOS 7/23/15 – 9/14/15 per Rule 133.307(c)(1)(A). The provider has waived its right to MFDR. PLEASE DISMISS AS TO THOSE DATES."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2015 through December 18, 2015	Inpatient Hospital Services	\$264,475.85	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services
- 28 Texas Administrative Code §133.10 governs the required billing forms and formats
- The insurance carrier reduced payment for the disputed services with the following reason codes:
 - 251 – The attachment content received did not contain the content required to process this claim or

service

- 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated
- P12- Workers’ compensation jurisdictional fee schedule adjustment
- 16 – Claim/service lacks information which is need for adjudication
- 193 – Original payment decision is being maintained
- W3 – Additional payment made on appeal/reconsideration

Issues

1. Was the medical fee dispute timely filed with the Division of Workers’ Compensation?
2. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
3. Which reimbursement calculation applies to the services in dispute?
4. What is the maximum allowable reimbursement for the services in dispute?
5. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. Was the medical fee dispute timely filed with the Division of Workers’ Compensation?

University Medical Center is disputing the carrier’s denial of payment for an inpatient hospital admission. The injured employee was admitted to University Medical Center on July 23, 2015 and discharged nearly five months later. Specifically, the injured employee was discharged on December 18, 2015. In its position, the carrier argues that University Medical Center failed to submit its medical fee dispute not later than one year after the date(s) of service as required by Rule at 28 Texas Administrative Code (TAC) §133.307(c)(1)(A).

To determine how the one year filing deadline for fee dispute resolution is applied to this inpatient hospital admission, the division considered three key requirements for inpatient hospital admissions from the medical fee guidelines:

- 28 TAC §133.10 (f)(2)(O) which states that the “patient discharge status” is required in order for the bill to be considered a complete medical bill as defined by 28 TAC §133.2 (4);
- 28 TAC §134.404(d) which applies Medicare billing policies including the requirement that an inpatient hospital bill contain a discharge classification code known as a Diagnosis Related Group or DRG code; and
- 28 TAC §134.404(f) which states that the reimbursement for an inpatient admission is calculated using the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula - a predetermined rate per discharge for inpatient hospital admissions based upon the required DRG code.

All of these provisions require that the hospital hold its billing until the inpatient admission is complete, and until the injured employee is discharged. The date of discharge itself can therefore reasonably be considered by the Division as day one for the purposes of applying the one year medical fee dispute filing deadline.

The division concludes that University Medical Center in this case was required to submit its medical fee dispute not later than December 18, 2016 – one year after the discharge date of December 18, 2015. Review of the request finds that the dispute was received on September 15, 2016. The division concludes that University Medical Center timely submitted its request for medical fee dispute resolution. The inpatient admission is therefore eligible for medical fee dispute resolution.

2. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?

28 Texas Administrative Code §134.404(e) states that: “Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

- (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
- (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.”

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

3. Which reimbursement calculation applies to the services in dispute?

§134.404(f) states that “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

- (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 143 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.”

Per the submitted documentation the requestor billed for \$1,797,064.73 for implantables under revenue code 0278. The insurance carrier paid a total of \$557,768.00 for the implantables. Per the requestor’s position statement “I am not questioning the payment of the implant invoices”, hence the dispute only concerns the facility specific reimbursement and not the implantables and will be calculated according to §134.404(f)(1)(B).

The division establishes the total Medicare facility specific amount in this case using the Medicare Inpatient PPS PC Pricer as a tool. The Medicare Inpatient PPS Pricer efficiently identifies facility specific payment factors and adjustment. Per Texas Administrative Code 134.404(f)(2) “When calculating outlier payment amounts, the facility’s total billed charges shall be reduced by the facility’s billed charges for any item reimbursed separately under subsection (g) of this section.” As the implantable services were reimbursed separately under subsection (g) the facility’s billed charges will be reduced from \$5,198,922.87 to \$3,401,858.14 taking out the billed charges for the implantables when using the Medicare Inpatient PC Pricer.

The following illustrates the division’s calculation of the total Medicare facility specific amount:

TOT DRG AMT:	Add back VBP CR (not applicable due to conflict with Texas Labor Code)	Total Medicare Facility Specific Amount
\$698,424.20	+ \$99.15	\$698,523.35

Note that a reduction identified as “VBP CR” on the *Medicare Inpatient PPS Pricer* was added back into the total DRG amount for this admission. “VBP CR” stands for Value-Based Purchasing (VBP) claim reduction (CR) which in Medicare is used to fund the Medicare VPB program. Medicare’s VBP program was implemented to monitor and improve quality of care provided at inpatient hospitals participating in the Medicare system. Consequently, the Medicare VBP program conflicts with existing Texas Labor Code (TLC) sections [413.0511](#) and [413.0512](#) which provide for the review and monitoring of the quality of health care provided in the Texas workers' compensation system. The fee rule for inpatient hospital services contains a conflict provision which explains that the Texas Labor Code in such instances takes precedence.

28 Texas Administrative Code §134.404 (d)(1) states “Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers’ Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.” For this reason, the VBP CR amount does not apply to inpatient hospital services provided in the Texas Workers’ Compensation system and was added back into the facility specific amount.

4. What is the maximum allowable reimbursement for the services in dispute?

§134.404(f)(1)(B) establishes maximum allowable reimbursement(MAR) by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Documentation found supports that the DRG assigned to the services in dispute is 003, and that the services were provided at University Medical Center. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$698,523.35. This amount multiplied by 108% results in a MAR of \$754,405.22.

5. Is the requestor entitled to additional reimbursement for the disputed services?

The total allowable reimbursement for the services in dispute is \$754,405.22. The insurance carrier paid \$754,405.22, no additional amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled reimbursement for the services in dispute.

Authorized Signature

_____	_____	4/5/2017
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	4/5/2017
Signature	Medical Fee Dispute Resolution, Director	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.